

ST. BARTHOLOMEW'S HOSPITAL JOURNAL



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No. 3

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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March, 1961

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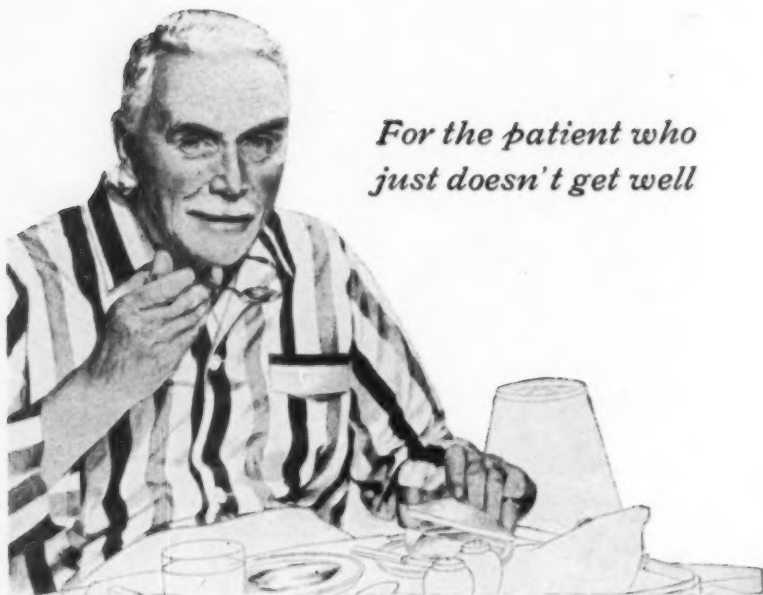
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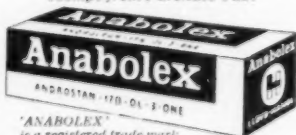
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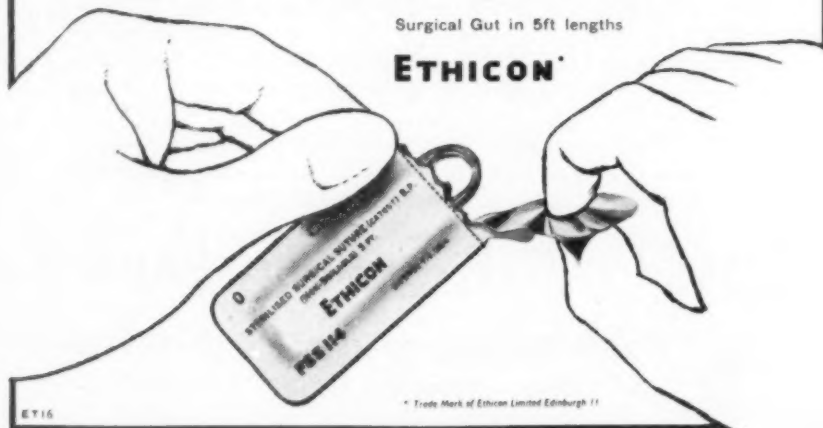
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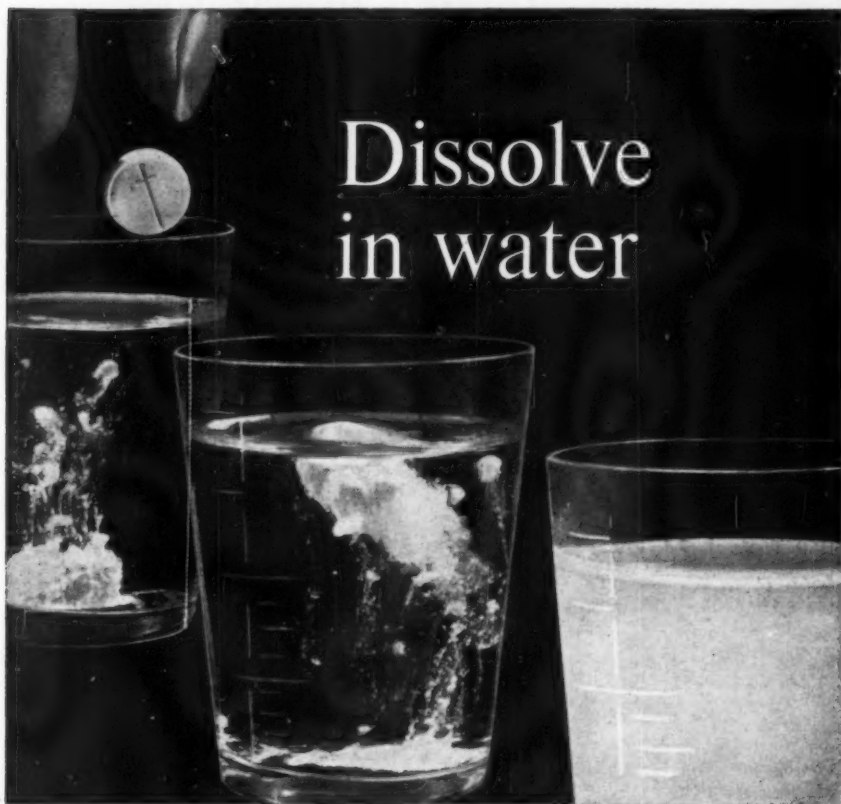


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ST. BARTHOLOMEW'S HOSPITAL JOURNAL



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MARCH, 1961

Editorial

A BRIEF GLIMPSE around the Hospital will reveal that few, if any of us are destitute; and yet, the matter of income continues to be a source of considerable discontent in the student body. Some complain that their income is insufficient to satisfy their essential needs and in a few cases this contention is probably justified; others say that although their income covers essentials, their life is dull because of the few luxuries they can afford. Whatever the case, all compare their income with that of their fellow, and this comparison contributes more to the discontent than any other single factor.

It is not in the nature of human beings to be satisfied with their own means, however adequate they may be, when their companions have better. Students are no exception and their attitude to money may not unfairly be likened to that of the Trades Unions.

With regard to subsidy, it is not reasonable to expect the authorities to contribute more than is necessary for the cost of education together with a basic living allowance, which does, in fact, take into account the occasional luxury. The way in which this allowance is distributed, notably by the means test, may not give satisfaction to all and has recently been under review; but viewed in perspective,

the principle of the means test seems to be the fairest way in which money can be allocated.

One great difference between the student and the worker lies in the fact that although the latter derive their income from one employer, be he private or municipal; the large body of students gain their money from two sources, namely the education authorities and the parents. Now parents are a pretty mixed bunch, and their assessment of what a reasonable income should be varies within wide limits. Those whose parents tend to keep a tight grip on their finances in many cases paradoxically blame the education authorities for their lack. On the other hand, those whose parents are extremely generous, sometimes to the point of indulgence, often become self satisfied and spendthrift. Working in the same community, the former will sometime or other compare himself with the latter, only to increase his discontent with his own circumstances, and it is unfortunate the blame will be laid at the feet of the education authorities.

We do hope that our income will adjust itself to the changing cost of living, but it is morally unjustifiable to expect the authorities to subsidise our visits to the theatre and public houses: this should be afforded through our parents or our own private means.

Fifty years ago

THE MID-SESSIONAL ADDRESS before the Abernethian Society in the Winter term of 1911 was delivered by Mr. Henry Butlin who took as his subject "Public Speaking, particularly in relation to Medicine." The text of this address is reproduced in full in the April edition of the Journal for 1911, and makes entertaining and most instructive reading. In his Editorial the Editor at that time writes:

"We wish we could reproduce also the charm of delivery which characterises all Mr. Butlin's orations; but we feel confident that all those who have had the privilege of knowing Mr. Butlin as a teacher will easily recall with affection his intonation and mannerisms, and, when reading his lecture, they will feel, in a measure, that they were actually present to hear him speak. It is always a great pleasure to receive instruction from a master of his art, but to be able to learn from a speaker of Mr. Butlin's fame a few hints on public speaking appeals to us as indeed a privilege."

Space permits us only to reproduce the following short extract from Mr. Butlin's address:

"Of orator's I have only heard, so far as I can judge, two in my life—Mr. Gladstone and Mr. Gough (the 'Temperance Orator'); but I am not sure of Mr. Gough, for I heard him when I was quite a child, and had never heard any fine speaker in my life before. My experience of Mr. Gladstone is limited to a single speech. In the time of the 'Bulgarian atrocities' I happened to have some orders for the House, where I had never been. One afternoon, in the early summer, having nothing particular to do, I thought that I would go down and hear what took place. I had no difficulty in finding a seat, and the son of some nobleman was making his maiden speech. But before he had finished the benches became filled with members, and the Strangers' Gallery was soon filled to overflowing, and my next neighbour said to me: 'Something is going to happen; I should not wonder if Mr. Gladstone is coming down to speak.' And, presently, Mr. Gladstone entered and took his accustomed place. When the young man sat down Mr. Gladstone rose, and his first act was to compliment the previous speaker. It was delightfully done. If I had been provided with pen and paper and sat hours in a quiet room I could not have

produced a more graceful or beautifully worded compliment. He then began to speak on the Eastern question. He described the cruelty of the Turkish soldiers and the sufferings of the Christians, and in such terms and with such power of language that we who listened could almost see the soldiers at their work, and hear the cries and groans of the wounded and dying. He summed up what the European countries had done for the Christians, what 'Holy Russia' had done. And when he stood silent for a moment, then asked in deep and tragic tones, 'And what has England done?' we lowered our heads, and were ashamed, and each one said to himself, 'What has England done?' I think, at that moment, we should have been ready to follow him even to Bulgaria; and, I am sure, if I had then been summoned to vote, I must have voted in whatever manner he had ordered me. For three hours and a quarter Mr. Gladstone spoke. Until then I had thought that I could never have listened to mortal man for more than an hour without fatigue and *ennui*. But, during all that time I had never wished that he should cease, and when he had finished I should have been content for him to have spoken longer. Few great orators are given to the world, and when there is one in this country by all means hear him if you can."

Calendar

MARCH

Sat. 25—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballantine

APRIL

Sat. 1—On duty: Dr. A. W. Spence
Mr. E. G. Tuckwell
Mr. C. Langton Hewer

Sat. 8—On duty: Medical and Surgical Units
Mr. George H. Ellis

Sat. 15—On duty: Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans

Thurs. 20—Abernethian Society: Canon Charles E. Raven, D.D., (Chaplain to the Queen)—"Disease of the Body Politic".

Sat. 22—On duty: Dr. E. R. Cullinan
Mr. C. Naunton
Morgan
Mr. R. A. Bowen

Abernethian Society

ON FEBRUARY 6TH, 1961, a Clinico-Pathological Conference was held, the first to take place at Bart's for three years, and certainly great interest was shown by the 160 people who came. Two cases were presented to Professor Scower and Dr. Stansfield by Miss Margaret Childe and Mr. David Gardner-Medwin, whose clinical diagnoses were widely discussed by members of the audience, and in part contradicted, but generally confirmed by Dr. Stansfield's pathological evidence. Professor Scowen chaired the discussion and summed up the cases. The President, in closing the meeting, commented on the fact that it resembled the form of the earliest meetings of the Society which were always clinical evenings.

Surely clinical demonstrators, case presentations and clinico-pathological conferences are the very salt of a medical instruction, and could play a much more prominent part in the curriculum. Perhaps the interest shown in this venture of the Abernethian Society will be conducive to their inclusion as an integral part of the teaching.

ON MARCH 9TH, Dr. D. Stafford Clark, M.D., F.R.C.P., Consultant Psychiatrist at Guy's Hospital, addressed a large meeting of the Society on "Psychiatry and the Law".

Often in the law courts today "expert" medical evidence appears to be falling on stony ground. It seems to be at the mercy of the whims of cross examination. Yet, looking beneath the surface, the reason is at once apparent. The verdict in a law court is obtained in quite a different way to the diagnosis of a psychiatrist. Law is an entirely man-made innovation based on the concept of Justice. There is a rigid structure of rules and definitions enforced with great flexibility by lawyers—the only people who really know what it is all about. To obtain a verdict it is essential to have an opposition and a cross-examination; for this is the best way of arriving at the truth. Psychiatry, on the other hand, has no blue prints on which to rely; it depends much on hypothesis. Diagnosis is only reached, on the basis of probability, from a differential diagnosis, which may comprise any number of possibilities. The lawyer, subjecting this to his own method, may feel the doctor a poor witness in court. Indeed, during the trial of Haigh for

the acid-bath murders the doctor's evidence for the defence, that Haigh was suffering from Paranoia, based on history, was dismissed as hear-say. In another case, the murderer of two children was undeniably mentally defective, but the court did not recognise mental deficiency as a disease of the mind and so he had to be "proved" insane. A judge once, in summing up a case, said of the accused: "He looks sane enough to me." Would he say of a newly built bridge, declared by an engineer to be unsafe, "It looks solid enough to me"?

"Expert" medical evidence would be much nearer the truth if obtained free of the methods of the law courts, by an independent tribunal; by a uniting of experience rather than a battle of experience.

Dr. Lindford-Rees proposed the vote of thanks.

Notes and News

WITH THE RAPID turnover of clinical students the Journal has a useful function to perform in publishing periodically notices of some of the services available to students and recently qualified men.

One such service, of which some may not be familiar, is Dr. McKane's "Employment Agency". Dr. McKane is the Adviser in General Practice to the hospital. He writes: "I am ready to help students in any of the problems related to General Practice, either in preparation for it or in settling into one when they have once become registered."

Dr. McKane gets many letters from doctors in practice, both in this country and abroad, asking for recently qualified men to fill vacancies as assistants with a view to partnership, assistants, trainee assistants and locum tenens. Many of these are excellent posts offering very good experience, but there is only any response from those applying for posts as "assistants with a view". This would seem a great pity and a great waste. The value to the potential hospital doctor of spending a period of time in general practice has been stressed time and again.

View Day 1961

View Day 1961 will be held on Wednesday, June 28th.

Engagements

HATCH-MOTTADELLI.—The engagement is announced between Dr. John Desmond Hatch and Signorina Antonietta Mottadelli Monticelli.

HURDING-HARDING.—The engagement is announced between Dr. Roger F. Hurdling and Joy E. Harding.

LODGE-DURDEN SMITH.—The engagement is announced between Dr. Alan Blakey Lodge and Claire Durden Smith.

SUGDEN-PARK.—The engagement is announced between Dr. John Sugden and Dr. Pauline Park.

Births

HOVENDEN.—On February 1st, to Anne and Dr. Brian Hovenden, a son (Charles Brian).

MILLWARD.—On February 19th, to Wanda and Dr. John Millward, a daughter (Helen Madeleine).

PAGET.—On February 21st, to Joan, wife of Dr. Cecil Paget, a daughter (Sarah) a sister for Nicola, Wendy and Nigel.

PORTIELLY.—On January 31st, to Wendy and Dr. John Portelly, a daughter.

WOOLRYCH.—On February 15th, to Ann and Dr. Michael Woolrych, a son (Thomas Geoffrey).

Deaths

ACTON-DAVIS.—On February 10th, Kenneth Acton-Davis, M.Ch., F.R.C.S., aged 78. Qualified 1911.

ARMITAGE.—On February 17th, Dr. Charles Ernest Augustus Armitage, aged 83. Qualified 1905.

BURKITT.—On February 1st, Dr. Frederick Thomas Burkitt, aged 69. Qualified 1918.

CUNNINGTON.—On January 21st, Dr. Cecil Willett Cunnington. Qualified 1905.

INGLEBY-MACKENZIE.—On January 17th, Surg. Vice Admiral Sir Kenneth Alexander Ingleby-Mackenzie, aged 68. Qualified 1916.

NICHOLSON.—On February 22nd, Dr. Cuthbert John Nicholson, aged 76. Qualified 1912.

SQUIRE.—On February 5th, Dr. Henry Fremlin Squire. Qualified 1918.

WOODFORDE.—On January 25th, Dr. Alfred William George Woodforde, aged 80. Qualified 1906.

Appointments etc.

Dr. E. F. Scowen has been appointed to the London University Chair of Medicine at St. Bart's Hospital Medical College.

The title of Sir William Collins Professor of Pathology in the University of London has been conferred on Dr. G. J. Cunningham in respect of his post at the Institute of Basic Medical Sciences.

The following have been elected Fellows of the Royal College of Surgeons:

Arthur Bates, Henry Poirier, Walter Graham Harris, Christopher Neville Hudson, Richard Loxton Rothwell-Jackson, Arthur Powell Wyatt.

Examination Results

The following have completed the examination for the Diplomas M.R.C.S., L.R.C.P.:—

Harrison, R. I. Evison, P. R. H.
Andan, A. Mackenzie Ross, R. K.

Students' Union

The results of recent elections for officers and representatives of the Students' Union Council for 1960/61 are as follows:

1. Executive

President: Mr. E. G. Tuckwell.
Treasurers: Professor G. W. Taylor
(in place of Mr. E. G. Tuckwell).

Chairman: Dr. D. A. McDonald.
Vice Presidents: Dr. A. G. Spencer.
(a) B.M.S.A. Representative: A. C. Howes.
N. Whyatt.

(b) Lady Vice President: Miss E. Knight.
(c) Athletics Committee
Chairman: P. A. R. Niven.
(d) General Committee Chairman: M. J. G. Thomas.

Honorary Secretary: J. A. H. Bootes.

Financial Secretary: G. T. Sharp.

Publicity Officer: J. Ind.

2. Student Representatives

Finalists: M. Bishop.
"Middler & Gynae": D. Metten.
"Kids & Specials": D. B. M. Howells.
M.O.P.'s & S.O.P.'s: P. Ross.

First Time Clerks & Dressers: J. Rushton.

Introductory Course: A. Frank.

Clinical Ladies Representative: Miss S. Cotton.

Third Year (& B.Sc.): M. Casewell.

B. Kasteliz.

Second Year: T. P. Dutt.

Miss W. Saunders.

First Year: A. Bailey.

Preclinical Ladies Representative: Miss M. Brown.

Dentals: A. Basharatulla.

Athletic Committee Chairman: P. A. R. Niven.

Secretary: Miss S. Cotton.

General Committee Chairman: M. J. G. Thomas.

Secretary: Miss S. Williams.

Change of Address

Theresa M. Vearacombe,
c/o Major C. A. Vearacombe,
H.Q., B.F.A.P.,
B.F.P.O. 69

DR. J. R. HAMERTON—After June 24th, 1 Winterstone Way, Ramsgate, Kent.

Until that date, mail will be forwarded from Watchfield, Dodds Lane, Chalfont St. Giles, Bucks.

DR. T. M. G. SHARE, 2 Curzon Court, Postarlington Road, Bournemouth.

DRAMATIC SOCIETY — BUSMAN'S HONEYMOON*by Dorothy L. Sayers & M. St. Clare Byrne*

PUBLICITY IS NOT usually the concern of dramatic criticism but, if underserved disaster is to be avoided in successive years, I must deplore the lack of publicity which preceded this performance. Over the two nights less than half of the seats were filled. There are some six hundred students in the college and the hospital, staff and nurses probably double this figure, families and friends would double it again. All too often organisers wring their hands over widespread student apathy, when apathy is the favourite victim of clever publicity which is not aimed at discerning minorities.

The audience enjoyed this play and its performance and that, as Noel Coward wrote recently, is the most important factor in considering any production. Although Dorothy Sayers might have been somewhat perturbed because her script was cut about, which was probably an improvement, some of the actors failed to portray her characters as she depicted them. John Jailler as Wimsey's manservant came nearest as Bunter. Nick Loughnan as Lord Peter Wimsey himself, although smooth and amusing, was often too arrogant and too talkative, lacking the practised reticence and the unruffled pose of Sayers' aristocrat. Susan Williams, playing Harriett Vane, Wimsey's wife, could not convey the sophisticated blue stocking intelligence which should dovetail with Peter Wimsey's mind.

The first act was inclined to drag and the actors galloped through their lines in an effort to shorten it with the exception of Patrick Kingsley who got away with a somewhat over-stated performance of the kindly country vicar. In the second act, we saw a great deal of smart ad-libbing which got the investigation of the murder away to a good start. The actors must be given credit for keeping up with themselves and Peter Wimsey at this stage. This brutal procedure which probably had nothing to do with the producer lent colour to the play which stayed with it until the end. The last act was the best because we were forced to appreciate fully the evening's best performances, those of Mike Stewardson and Anita Roche as Frank Crutchley, the murderer, and Miss Titterton, his elderly girl friend. His desperation was chillingly convincing and her spinster dreams and real frustrations professionally put across.

It is not an over-simplification to say that the play was not well produced, or rather, it was under-produced, but the performances of the supporting roles held the play together, made it lively and worth watching. John Graham Poke, the local builder, had an accent which was a joy; Diana Clark's charlady and Ben Bennett's debt collector were colourful and delightfully vulgar, the law, slow and solid was faithfully played by Simon Phillips and Bob Shearer.

S. C-S.

I've heard that the African pygmy,
And should I be wrong you will wig me,
To achieve social status
Will eructate flatus
In time to his gut's borborygmi!

OBITUARY*Sir Harold Gillies*

SIR HAROLD GILLIES will always be remembered as the father of modern plastic surgery and when he died on September 10th, 1960, at the age of 78, all those engaged in this branch of surgery in the British Isles, and many in countries overseas, felt a deep sense of personal loss in having been first or second generation pupils of the great master.

The speciality has grown so fast in the last twenty years that it is difficult to realise that Gillies was a real pioneer and that for many years he fought a hard and sometimes frustrating battle to establish plastic surgery as a major speciality equally necessary in peace and war. The status which plastic surgeons now enjoy in the United Kingdom and in most Commonwealth countries is, in full measure due, to his untiring efforts.

In 1915, when thousands of patients with gross facial wounds started to pour into British Hospitals from the battlefields of Western Europe there was no one available to treat this type of problem and Gillies, who until then had been engaged in ear, nose and throat work, accepted the challenge and created the first plastic unit at Sidcup in 1917.

He gathered round him a devoted team of surgeons, dentists and anaesthetists, and the outstanding work which was done at Sidcup soon received world-wide recognition. Gillies was appointed O.B.E. in 1919 for his wartime services, this was followed later by a C.B.E. and finally a knighthood in 1930.

After the First World War, Gillies experienced considerable difficulty in convincing his surgical colleagues of the necessity for a new specialty and it was only after much delay and disappointment that he was finally elected to the full consultant staff of St. Bartholomew's Hospital in 1932. Nevertheless, it was a source of satisfaction to him that Barts was the first London teaching hospital to appoint a plastic surgeon to its staff and, although few beds were available, the new department soon attracted patients from all over the country.

Gillies was an unorthodox, but talented teacher, who did not suffer fools gladly, but he was always prepared to spend endless time imparting knowledge to those who showed determination to learn no matter how junior or inexperienced they might be. He took little part in student teaching but his

operative and out-patient sessions were heavily attended by surgeons from overseas, many of whom are now the leaders in plastic surgery in their own countries. Those old Barts men who had the privilege of being his house surgeon and are now engaged in other branches of surgery will remember with gratitude how much they learned about fundamental surgical technique from their old chief.

His writings were numerous and covered a wide variety of subjects including burns, congenital deformities, facial fractures, irradiation injuries and the design of skin flaps. The book published in 1920 on *Plastic Surgery of the Face* recorded his unique wartime experience at Sidcup, and in 1957 at the age of 75 he produced with Ralph Millard another outstanding book *The Principles and Art of Plastic Surgery*. In these two major works we are fortunate in having a record of some of the massive achievements of this great surgeon presented in a style which is completely unorthodox and individualistic and typical of the man himself.

Gillies had an amazingly inventive and ingenious mind and these qualities combined with the fact that he was a superb craftsman made him great. He was at his best when faced with a problem which to everyone else seemed insoluble and he would delight in putting forward not only a solution but perhaps two or three alternative plans some of which would probably seem more than a little fanciful to any other surgeon.

As an operator he displayed great gentleness, patience and meticulous attention to detail, but a complete disregard for time which was often exasperating for those working with him.

Between the Wars in addition to a very large private practice, Gillies held active appointments at many hospitals in and around London and served as Consultant to the three Services and to the Ministries of Health and Pensions.

Gillies was responsible for planning the units which received the Service and civilian casualties requiring plastic surgery in the Second World War, and the efficient organisation which he built up formed the basis for the plastic surgery services in the National Health Service when it was inaugurated in 1948.

In addition to bearing heavy responsibility in an advisory capacity Gillies was actively engaged in treating casualties at one of the

major units at Basingstoke throughout the War years and during this period he trained many surgeons who were later appointed as plastic specialists in the new Health Service.

Although he had so many interests outside plastic surgery, Gillies' enthusiasm for his work never flagged and he was still operating and grappling with some of the problems which had previously eluded him to within a week or two of his death.

Over a period of nearly half a century, Gillies occupied a unique position in international surgery and although he is no longer with us, his name will endure as a great master surgeon and the founder of plastic surgery as we know it today.

P. H. J.

I FIRST MET Harold Gillies when the Medical Art Society was first formed thirty years ago. He undertook this fresh activity with the zest so typical of him in everything he began. I well remember the original meeting when he was our host at the Garrick Club. The Senior Member of our committee was the late Sir Leonard Hill, the physiologist, who I remember in those days had the initiative to organise a private view of his work in Japan, with the proceeds of which he bought a car. Gillies was less successful financially with his painting, but it was a hobby which gave him constant and increasing pleasure. As an artist, he was always original and he had a real feeling for colour, light and composition.

My other contact with him was as a fisherman. He belonged to the famous Houghton Club on the Test at Stockbridge. His love of this sport rivalled his affection for painting, and he was as much an artist in casting a fly to a difficult fish as he was with brush and colour.

He was a Rowing Blue and a golfer of international status, in which latter sport one of his innovations was to drive his ball from a tee of unusual height. This on some occasions was actually a bottle.

He was a man who would never grow old. Arteriosclerosis made several attempts to diminish his persistent youthfulness but its attacks never succeeded. He was a *bon viveur*, and indeed there were few aspects of life in which he did not find perennial enjoyment.

Those who knew him—and they were many—will miss his vivacious and enthusiastic personality.

G. L. B.

James Seymour

James Seymour died on November 27th 1960, as a result of injuries received in a road accident three days before. The death, in such circumstances, of a young man of rapidly maturing promise will have been regretted by all who were aware of it; to his friends it has brought a poignant sorrow and it is difficult for them to realise that his strong, lithe figure, quiet voice, shy smile and charming personality have passed from this world.

He was one of twins born in 1921 in India, where his father was stationed in connection with an engineering project. Much of his childhood was passed in Kenya and Natal, where he was educated. Having early expressed the wish to become a doctor he came to England shortly before the War and entered the Medical College here. In 1945, he obtained the London M.B., B.S. degree and then held house appointments, first with Mr. Rupert Corbett and later to the Neurosurgical Unit at Hill End. After an appointment in the Blood Transfusion Service his lasting interest in otological problems was aroused when he acted as assistant to the late Mr. Garnet Passe. Returning to South Africa he obtained practical experience in surgery and came to England again in 1948 with the intention of obtaining a higher surgical qualification. However, instead he became Bernhard Baron research scholar at the Middlesex Hospital and commenced the series of investigations on the inner ear which were to occupy him in the Feren's Institute for the remainder of his life. Here he was provided with facilities which his own hospital still lacks—a well equipped research laboratory, expert technical assistance and an income sufficient to enable him to live in the very modest way which was all he asked. He thrived in this environment, his scientific curiosity revealing the problems and his intelligence and imagination the means by which they might be attacked; to these qualities were added the patience, determination, manual dexterity and single mindedness which enabled him to work unhurried towards their solution. His work on Ménière's Syndrome had gained him the Norman Gamble prize of the Royal Society of Medicine in 1955 and this year he was to have given an Aris and Gale lecture at the Royal College

of Surgeons. Though he had published little, the fruits of his labour were ripe, and indeed, in process of being gathered when he died. He had achieved a wide reputation for his work on the blood supply of the inner ear and the influence of the sympathetic nervous system upon it. This fundamental research illuminated the problem of Ménière's Syndrome and would almost certainly have led to an increased understanding of other problems in otology. He gave much thought also to the nervous control of intracranial vascular circulation, and had he lived it is probable that he would have made a real contribution in this as well as other fields.

He was deeply interested in neurology and neurological surgery, and had always expressed his intention of returning to this work at the conclusion of his research. Indeed, he regularly worked in the Neurosurgical Department of the hospital each year. His intelligence applied to clinical problems, and the attention and sympathy he gave to his patients were quite outstanding. He was, moreover, a careful surgeon as well as a most able and loyal assistant. Had he returned to clinical work he could undoubtedly have become an outstanding neurological surgeon.

Although he had not married and was a shy man, he was always interested in people and made many friends. He could enjoy a social gathering but was happier in the company of those whom he knew intimately. Of recent years he had passed much of his leisure in Cumberland, where his uncle is in general practice. He derived increasing satisfaction from these visits to the valley in which he now lies buried, becoming a keen and able fly fisherman—"a pupil in ten thousand" as his expert teacher in this field described him. More recently he added farming to his interests in the area and found pleasure and relaxation in helping develop the land of one of his closest friends. A strong swimmer, when in London he endeavoured to swim daily as a means of maintaining physical fitness. Strangely, for one of his strength and energy, he was a fastidious eater. A competent artist, he had from his undergraduate days made excellent drawings of operations and pathological specimens in the Neurosurgical Department, and indeed

had assisted with the illustration of several papers from the department.

James Seymour's personality was quite uncommon. In him were combined the sensitive temperament of an artist and the intellectual curiosity of a scientist; an acute critical faculty with understanding of others'

viewpoints; absolute integrity and quiet faith. The great promise which was being so modestly fulfilled cannot now be realised and his personal charm is but a memory. But those who mourn his death are thankful for his life.

J. E. A. O'C.

AN EPIDEMIC OF MEASLES

By Dr. L. S. Castleden

AFTER SEVERAL YEARS in the same locality the General Practitioner can see and anticipate the spread of infectious diseases in his area. In the case of Measles the progress of the infection can be particularly easily followed. Not only is the disease readily recognisable but it is also notifiable and sufficiently severe for the doctor to be consulted in most cases.

The degree of immunity conferred by previous attacks is absolute so that the susceptible population is usually confined to the younger children. In these days when even the poorest families are highly mobile, there is a tendency even in Rural areas for smaller epidemics every other year, rather than more sweeping epidemics every five years or so.

Our area consists of a central small town (pop. 4,000) which has a secondary modern school (11-17 years) and a primary school as well as a small private school. Surrounding the central township are six smaller villages within five miles with primary schools. Some 15 miles away are four larger towns, each with complete quota of primary, secondary, high and technical schools. Although we do not see cases from these areas, infections often smoulder in their larger communities.

On two occasions I have been lucky enough to observe epidemics developing from the primary cases and they will serve to illustrate the spread of the disease.

In August 1958, a small family of parents and three children living in the central township returned from a visit to grandparents in Scotland. The middle child age 12 years was observed to have a "cold" and

red eyes and a loud cough, whilst in the train. The typical eruption appeared two days after their return. Meanwhile visits had been paid to neighbouring children with the result that the next batch of cases included not only the other children of the family, but also several living in the town. The third batch of cases was more numerous and included children attending both the primary and secondary schools. Thus in their case, the epidemic in the central town was explosive and at the end of a month 95 per cent of the non-immunes in the schools had been attacked. These resulted in secondary cases amongst their own families. Thence the infection spread to two of the peripheral primary schools in October and eventually the last cases were seen early in November, leaving several of the smaller village schools unaffected.

The second epidemic to be described occurred last year. Late in August, I was called to see a boy, aged 3, who has infantile eczema. He had developed a severe cold and cough accompanied by a flowering of his rash, after a visit to a seaside resort. The rash in the mouth and reddened eyes made it probable that this was a case of measles. There were three other boys in the family who developed the disease, one attending the secondary school in the central town, the others were at the village primary school.

The result was an explosive and complete epidemic in the local village primary school but only one case at the secondary modern school where immunity was high.

However, the disease spread to the larger towns to the North and West and there it stayed until Christmas parties mixed these

urban children with those attending the primary school at the village to the westward. As this school had not been affected in 1958 the attack rate was again high. Thence the infection was transferred to the primary school at the central town where only the younger, susceptible, children were attacked.

Another remarkable feature about measles is that the severity of the disease varies so much. In the first epidemic many cases were severe. Some children were desperately ill. One fatality occurred in spite of oral penicillin treatment. This was due to massive pneumonia and not to encephalitis. There were a number of cases with otitis media and broncho-pneumonia, who required antibiotics.

On the other hand the present epidemic is of a much milder disease. The rash is

typical but there is less conjunctivitis and so far both pulmonary and middle ear complications have not been observed.

That a familiar lack of resistance may account for the severity of some cases is suggested by the fact that an uncle of the only fatal case also died of measles. This was some thirty years ago. It should be remembered that this was when antibiotics and sulphonamides were unknown and therefore complications were not easily treated.

This brings one to the vexed question of "umbrella" treatment with sulphonamides and penicillin derivatives. In some specific cases this may be desirable, but each case should be considered carefully. My own opinion is that in an epidemic of "average severity measles", only established complications should be treated.

HISTORICAL DIAGNOSIS

By J. C. Crawhall

Second Meeting of the Fifth Session (of the Medical and Philosophical Society of St. Bartholomew's Hospital, 1799)

Mr. Abernethy President

Mr. Macartney related the case of a gentleman who had sores on his penis which were considered venereal he himself did not however think them so. Mercury was persevered until the Gums were made exceedingly sore whilst taking mercury blotches broke out on various parts of his body He was directed to take the nitrous acid which seemed to produce no effect alone but the oxygenated miuriate of potash being conjoined with it a complete salivation was the consequence The liver seemed to be particularly affected by the Medicines as a complete stoppage to the secretion of bile took place

pro tempore the stools were of a clay colour.— In this case there seemed at this time to be no particular danger he had a blister on his Breast but a fever supervening he became exceedingly emaciated and the efforts that were made to restore his strength by Bark etc. proved ineffectual as he died suddenly.

The acid which was administered for the eruption removed them pro tempore Mr. Macartney did not consider them as venereal they having made their appearance whilst the constitution was under the influence of mercury.—

Mr. Macartney considered the effect of the Medicines on the liver as curious as sometimes the Bile was secreted at other times it was not.

(Authors' Note.—The punctuation is reproduced as written in the original minute).

THE HISTORY OF THE OSLER CLUB OF LONDON

By Dr. A. White Franklin

*Read to the Osler Club's Combined meeting with the Harveian Society
November 16th 1960*

OUR OSLER CLUB of London is but one of a galaxy of eponymic Clubs and Societies, as it is but one of many commemorative Osleriana. The Club was conceived at Saint Bartholomew's Hospital in 1927 and born in 1928. Neither parent, neither I nor Walter Reginald Bett, would claim sole credit for the idea of a student's club for the study of medical history: it must remain an example of synchronised double parthenogenesis. I have told elsewhere* how Bett, inspired by Harvey Cushing's *Life of Osler*, insisted that the Club be called The Osler Club, and how I was converted by a visit to Oxford where Bill Francis showed us the books in The Library at 13 Norham Gardens, where Lady Osler gave us a stately tea and where I bought my copy of *The Life*.

It was my great good fortune to own encouraging parents, who allowed their home, until it was burnt in 1935, to be the Club's headquarters and regular meeting place, and my greater good fortune to have four friends who allowed themselves to be drawn into the plan. We had all toured America in 1926 with the Cambridge University Medical Society. We had all, notably in Montreal, in Philadelphia and in Baltimore felt the potent magic of Oslerolatry. Indeed writing up the tour for the *Landmark*, I called Canada "the land that gave Osler to medicine". Pickering in the Oslerian Oration for 1960 described preparatory meetings in the students' refectory at Saint Bartholomew's.

And then on Monday, April 30th, 1928, the first meeting of The Osler Club of London was held at 27 Wimpole Street.

"G. W. Pickering read a paper on Louis Pasteur his life and his work. Dr. Singer showed some reproductions of Pasteur's youthful drawings, lent by the Royal Society of Medicine. An informal discussion followed, dealing chiefly with Pasteur's predecessors, Redi, Paracelsus and Leeuwenhoek. Pasteur's classical

works were displayed, and an interesting collection of photographs relating to the Pasteur Institute and the 'Pastoriens'."

Pasteur was chosen because Osler thought that his life should be the inspiration of every medical student. He had written an introduction to a translation of the Valléry-Radot biography, a copy of which was sent in 1911 through the generosity of Henry Phipps to the Library of every Anglo-American medical school.

How happy that the first speaker, Pickering, the most brilliant medical student of his year at Cambridge, should now occupy Osler's own chair in Oxford.

The five other founder members attended. Bett and Franklin, T. F. McNair Scott, now research Professor of Paediatrics in Philadelphia; Hal Mansell and C. F. Watts—Hal volatile, brilliant, a pianist with a passion for Vesalius, whose career as cardiologist ended so prematurely in 1941; Cecil Watts drowned in 1930 in a yachting accident leaving Jackson Burrows, orthopaedic surgeon, as his legacy to the Club.

The second meeting of the Club (tonight's is the 183rd) remains in my memory as an example of the heights to which medico-historical meetings can rise. The tercentenary of Aselli's discovery of the lymphatics was celebrated in six papers—by Bett on Aselli himself, by Franklin on Joyliffe and Cruikshank, by McNair Scott on Bartholin, and on lymphadenoma by Watts. The subject was brought up to date by papers on modern aspects of lymphatic study from Wilfrid Le Gros Clark and Scott Williamson. Important books and pictures relating to the men and their work were displayed and handed round during the meeting. Much hard work had gone into its preparation.

The third meeting took us to Sir D'Arcy Power's library to "see, handle, and smell, but not to lick the books" the fourth to The Open Arms in Oxford to be regaled by Gibson with the letters Osler had written to him, by Bill Francis and R. H. Hill with a tour of the Library and to begin our long

* *Med. Press* (1949), 122

and close friendship with John Fulton, who became Treasurer in 1930.

And then on July 12th the first Oslerian Oration was given by Sir Wilmot Herringham.

So our method of work was revealed, our prime object to encourage among medical students the study of medical history. The man, the work, the book, these were to be seen first in the context of their own time. What had been their effect then, their impact? What had grown out of the work? Where does the subject stand today? The history of medicine belongs properly in the laboratory and in the ward, and plays a humanising part in educating doctors.

The second aim was to keep green the memory of William Osler. In those first years, no member of the Club had actually known Osler. We were to find his influence strong in those, and they were many, who called him friend. We could see the golden afterglow upon the mountain tops, and feel how warmly that sun had shone, in the kindness and the help from which we benefited because we were the Osler Club.

There were guests of honour at our meetings—Charles Singer and L. W. G. Malcolm of the Wellcome Historical Medical Museum at the first, Singer, Arturo Castiglione, Geoffrey Keynes at the second, and at the first Orator, J. D. Rolleston and his distinguished brother, Sir Humphry, Thomas Lewis, Walter Fletcher, Andrew Balfour, Squire Sprigge.

During the academic year September 1928, to July 1929, three special meetings took us to the Wellcome Historical Museum, to Geoffrey Keynes' Library and to hear Sir Archibald Garrod give the second Orator. At the eight other meetings, fifteen papers were read by members (Bett scoring six) and five by close associates. Fifty meetings were held in the first five years, a pace too hot to maintain. On our tenth birthday in 1938 there had been 71 meetings and there were 29 ordinary members, 12 Honorary members, older men and established historians, with seven Friends including Harvey Cushing, D'Arcy Power, W. W. Francis and Geoffrey Keynes. I remained Secretary and now Paterson Ross was Treasurer. Bett, as ever the inspiration of the Club, the chief deviser of its programmes and our contact with the Diplomatic Corps, was Foreign Secretary. His tasks were keeping touch with corresponding members, the medical historians of other lands, and reporting on international

conferences.

In the world of the gathering storm, the Club sank into a slumber from which it was roused in 1947 with Dr. Carlyle Lyon as Prince Charming to our Sleeping Beauty. The history of the re-awakened Club must await another day, but I must mention the Club's part in providing a commemorative plaque to be placed by the University on Osler's old house in Oxford.

A word too must be said of our literary activities. Many papers read to the Club appeared ephemerally in *Hospital Journals*; one day the Archives of The Osler Club will, I know, begin to appear on your bookshelves. In 1930, Robb-Smith proposed that the Club edit a selection with a handlist of all the writings of Sir D'Arcy Power in honour of our Friend's 75th birthday and Lord Moynihan presented him with a specially printed and bound copy in January 1931. In 1949, the *Selected Writings of Sir William Osler* was edited. Both were published by the Oxford University Press. A third volume, a tribute to our faithful S. Damian, will shortly appear.

May I make a sad quotation from myself? "A few old faces and old voices remain to link the second foundation with the first, but those who were in at the beginning know that for them it cannot be the same. Their own youth, in which the Osler Club played its inspiring part, cannot return." I like to think that their part in the Club meant something to our older friends, D'Arcy Power, Bill Francis, A. P. Cawadias, J. D. Rolleston, Warren Dawson and Geoffrey Keynes and that it helped and inspired such loyal members as Wilfrid Le Gros Clark, James Paterson Ross, John Fulton, George Pickering, Clifford Wilson, John Hunt and Stephen, now Lord, Taylor of Harlow, acting Secretary 1934-5.

What of the new Osler Club and its future? The violent growth of the last few years to a membership of 240, the success of the programmes, the unexpected fact that we have survived the departure overseas of Walter Bett, show that The Osler Club is still full of life. With our Friend (in the technical Osler Club sense) Dr. Tom Cotton here, I must choose my words carefully. Through his posthumous munificence the Club will be attached to the Royal College of Physicians and so William Osler, our little lamp, will be linked to that great beacon light, that other William—Harvey.

THE ASSESSMENT OF FITNESS FOR OPERATION IN CARDIO-VASCULAR AND RESPIRATORY DISEASE

By Dr. N. Courtenay Evans

THERE IS LITTLE doubt that even in the apparently physically fit, major surgery may be complicated both at the time of the operation and in the post-operative period, by medical problems, mainly cardio-vascular or respiratory. These complications can sometimes be prevented and often forecast by careful general examination of the patient's history and of the patient. Reassurance as to the patient's ability to stand operation, helps to produce the right frame of mind and his confidence that all will be well.

In the impaired life, particularly in the elderly or aged, the type of operation has to be considered carefully by the physician. These fall into four groups which are as follows:

1. Trivial or minor operations from teeth extraction to haemorrhoidectomy.
2. Major but not essential operations as, for example, herniotomy and other repair procedures, and the possible developments from an operation being postponed, must be considered in the knowledge that an emergency operation may later become essential with greater operative risk.
3. Essential operations, but not those for carcinoma, as for example, perforated peptic ulceration.
4. The major group consists of those operations performed for malignant disease.

THE PATIENT

The patient may be young and fit and clinical examination is satisfactory. In all major surgery particularly for malignant disease, a chest X-ray is essential. It is a record of normality in any post-operative complications which may occur. Unexpected lung abnormalities, such as active tuberculosis, or metastatic deposits, may modify the operative procedure if known beforehand.

In the over-forties, a cardiogram is advisable, as latent or old degenerative disease of the heart, may be revealed. The surgeon is warned, and it may be wise to warn the relatives of an increased risk. The anaesthetist makes his plans with the special knowledge of cardiac abnormality, and avoids

cardiac irritants and hypotensive drugs, and is more than careful to avoid even temporary hypoxia.

A blood count, blood urea estimation and a laboratory examination of a mid-stream specimen of urine should be routinely carried out before major surgery is attempted in all but urgent emergencies.

In the elderly, it is common to find cardiographic evidence of previously unrecognised and symptomless cardiac infarction. This is probably no contra-indication to surgery, but it is a valuable fact for the surgeon and anaesthetist to know.

It is, however, the patient with concomitant disease, who is the main problem. Cardio-vascular and cerebro-vascular disease, respiratory disease, diabetes mellitus, blood diseases, acholuric jaundice and haemolytic anaemia, haemophilia and thyrotoxicosis are some of the more common diseases found, which may complicate a straightforward surgical problem.

CARDIO-VASCULAR DISEASE

Hypertension is one of the commonest cardio-vascular abnormalities. If there are no symptoms and the urine, the cardiograph, the heart X-ray and the clinical examination of the heart reveal no abnormality, little variation in surgical methods need be made. Kidney function tests are automatically done before prostatectomy. Bleeding may be profuse and extra care should be taken to avoid it, as severe haemorrhage may precipitate arterial thrombosis in a coronary or cerebral vessel.

An illustration is given of a man suffering from carcinoma of the colon. He was anaemic, haemoglobin 52 per cent, his blood pressure was 190/90 and there was an apical systolic murmur which was probably due to the anaemia.

The E.C.G. showed slight depression of the ST waves in the chest leads, again probably due to the anaemia. The X-ray showed a little calcification in the aorta and a pushed-up normal sized heart.

The anaemia was corrected by blood transfusion. Resection of the sigmoid colon was then done a week after admission and no complications occurred from a cardiac point of view and the patient made a good recovery.

Cardiac infarction makes operation inadvisable until three months have elapsed and all signs of failure are absent. Even then, only very essential operations are advisable and their extent should be restricted. If the infarction is several years old and there is no gross cardiac enlargement or angina of effort, any operation can be contemplated with reasonable hope of no complications from the heart. Anaesthesia must be carefully planned to avoid any chance of hypoxia.

Illustrations of two cases, both with low cardiac reserve.

The first case is that of a man aged 75, who was admitted for operation for carcinoma of the bowel. He gave a past history of coronary thrombosis three years previously, and a right hemiplegia a year previously. Three days before admission to hospital, he had further pain in the chest.

Serial E.C.G. suggested, and eventually confirmed, that he had had a further posterior infarct, and operation was postponed for five weeks while treatment was given for the heart condition which was complicated by a respiratory infection. Five weeks after admission he was enormously improved, his blood pressure had risen to 170/110 and his chest was clear. Operation was carried out after six weeks pre-operative treatment and the patient made an uneventful recovery from this.

The second case is that of another patient who was admitted for a carcinoma operation who had had a coronary thrombosis a year before.

The heart was found to be enlarged and there were signs of congestive heart failure. The E.C.G. showed the scar of an anterior cardiac infarct.

Operation was postponed but not for a sufficient length of time.

He was treated with Digoxin and Mersalyl.

Operation was performed a fortnight after treatment had been started. Four days after the operation urinary output became poor, his temperature rose to 101°F and he quickly became cyanosed and breathless. Ileus occurred and he died on the twelfth day after operation.

The lesson to be learnt from these two cases, is that operation may have to be postponed for considerable time before it can be attempted with a reasonable hope of success.

When angina of effort and angina at rest are present, much stricter assessment is necessary. Life-saving surgery for carcinoma is reasonable, as is essential non-carcinoma surgery. Prostatic obstructions with severe kidney damage resulting, is a good reason for operation in this type of cardiac disease. Repair operations are as a rule inadvisable, but if life is being made a burden, operation can be attempted with a reasonable hope of no irremedial cardiac complications.

An illustration of angina with high blood pressure, is that of a woman aged 66, who had a serious carcinoma operation with no ill-effects.

The blood pressure was 230/130. E.C.G. showed ST changes in the chest leads of cardiac ischaemia.

She was given Aminophylline by mouth before operation, but no other treatment.

It must be remembered that if the operation goes smoothly and no surgical complications occur, the heart will behave, but with ileus, post-operative haemorrhage or anastomotic troubles, cardiac complications supervene quickly, with the resulting lowering of the cardiac reserve and frequently with the death of the patient.

VALVULAR DISEASE OF THE HEART

To assess this type of heart abnormality, clinical, radiological and cardiographic investigations should be made. A history of congestive heart failure must not be lightly dismissed, even if no failure signs are present at the time, as a low cardiac reserve is probably present. With no enlargement or only moderate enlargement, and a regular rhythm combined with an aortic valvular incompetence, the patient is a reasonable risk for most operations.

With mitral stenosis, pre-operative Penicillin and Digoxin are probably advisable. Post-operative auricular fibrillation is a common occurrence in patients with mitral stenosis. The pre-operative digitalis will control the ventricular rate and in a few days the rhythm usually returns to normal.

When heart failure is present, with or without auricular fibrillation, treatment must be given for two or even three weeks before any essential operation. This is the type of case where carcinoma would be the only excuse for surgical interference. Consider-



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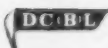
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ably increased risk will be run and pre-operative Penicillin and other antibiotics post-operatively, should be given. Anaesthesia should be discussed with the anaesthetist.

Congenital heart disease is rarely a problem in carcinoma patients and decision can usually be made easily. The cyanotic group must be regarded with great caution and only life-saving operations advised.

Syphilitic heart disease has a bad prognosis and extensive surgery would not be indicated and palliative surgery advised.

An example of valvular disease of the heart is that of a man of 78, who had had sub-acute bacterial endocarditis affecting the mitral valve, four years previously and had been treated for a long period with Penicillin with excellent results.

He was found to have a carcinoma of the rectum and it was decided in spite of the heart condition, to operate.

The heart was moderately enlarged and there was an apical systolic murmur which was conducted outward. Blood pressure was 150/90 and pulse 76/min. and regular.

The E.C.G. showed some sagging of the ST complex in leads 1 and 2 and X-ray of the chest showed some moderate enlargement of the heart and some atherosclerosis of the aorta. The complete operation was carried out without complications. Penicillin was given for two days before the operation and continued for one week after operation.

ARRHYTHMIAS

Auricular fibrillation and auricular flutter can be reasonably controlled by digitalis. With reasonable cardiac reserve and little or no change in heart size, operation can be carried out for most conditions.

A man of 72 was admitted for an operation for carcinoma. On admission his blood pressure was 190/90, and X-ray showed a full sized heart. E.C.G. was not done before operation.

Two days after operation, he developed auricular fibrillation and was given Digoxin intravenously.

The auricular fibrillation continued for two days and then the rhythm became regular and no further arrhythmia occurred. Recovery was uneventful after this.

Not such a satisfactory result occurred with another man who was first seen in 1950 at the age of

49, when he was found to have auricular fibrillation which had probably been going on for nine years previously.

Heart X-ray was normal and the blood pressure was 150/100. There was no evidence of valvular disease of the heart and the E.C.G. showed only the auricular fibrillation. An operation for a low level fistula was successfully performed without complications.

Ten years later he returned to the hospital with symptoms in the bowel which was diagnosed as a polyp in the colon and malignancy was suspected. He also had some gall-stones. Blood pressure was 210/120, the heart was enlarged and auricular fibrillation was still present. E.C.G. confirmed the auricular fibrillation and now gave evidence of disease of the heart muscle.

This was a patient who now had chronic myocardial disease and was not a good operative risk.

Operation was performed and the polyp was removed and found not to be malignant. Gall-stones were also removed. There was some pyrexia after operation and on the fourth day he became hemiplegic and the hemiplegia has remained.

RESPIRATORY DISEASE

Very many patients have bronchitis and a week or ten days pre-operative treatment can enormously help the post-operative condition and prevent complications. All smoking should be stopped and physiotherapy started, in particular, percussion drainage and postural drainage. Breathing exercises are also given. The sputum should be examined in the laboratory and antibiotic sensitivity estimated.

Penicillin can be started and is usually effective if it has not been given before. It has the advantage of causing few complications. The patient must always be asked if he is sensitive to antibiotics. Broad spectra antibiotics can cause diarrhoea and should be kept for the post-operative period, as a general rule.

In the majority of instances, Syrupus Calci-drine (Abbott) and Sod. Chlor. mixtures in hot water, are useful, but the expectorant mixtures are of little value. Inhalations of Alevair, a detergent fluid for liquefying the sputum, are sometimes helpful as are also Neo-epinine sprays.

This is an example of prolonged pre-operative treatment with a patient with a long history of bronchitis, a suggestive history of emphysema, heart failure and a poor cardiac reserve.

This patient collapsed after an enema and the blood pressure which had been 120, remained at under a 100 systolic, for 24 hours.

The X-ray of his chest showed some calcium in the aorta, some pleural thickening at the left base and a normal sized heart. The E.C.G. showed sinus arrhythmia, right axis deviation and an abnormal T wave in AVF. Tachycardia was present between 90 and 120, for the whole pre-operative period.

He was treated with Penicillin by injection, percussion drainage and breathing exercises. A mixture of ephedrine and phenobarbitone (Syrupus Calci-drine) was given by mouth and he was encouraged to walk about his room and not remain in bed.

Operation was performed four weeks after admission without any ill-effects. A prostatectomy also had to be performed three weeks later, also without any ill-effects, and he left the hospital four months after admission in good health.

A man of 74 was admitted for operation for carcinoma. He gave a history of razor-grinding for 50 years. X-ray of his chest showed a full sized heart with calcified apical lesions. Sputum was negative for tubercle bacilli.

Clinical examination showed rales at both bases. Blood pressure was 148/80. The E.C.G. showed abnormal T waves in leads AVF and chest leads, V3, 4 and 5. This man had chronic lung disease, with bronchitis and inactive tuberculosis, and a considerable amount of generalised arteriosclerosis.

He had three days treatment with Penicillin, Physiotherapy and ephedrine and Aminophylline.

After operation, the blood urea started to rise and he died in uraemia on the tenth day after operation.

PULMONARY TUBERCULOSIS

Patients should be nursed in single rooms, unless in a sanatorium, and sputum tested to exclude open cases. Even with a pre-operative negative sputum, post-operative conditions may cause temporary live tubercle bacilli to appear. This fact must be remembered in the nursing of these patients.

If activity is present or even only suspected, a course of Streptomycin and P.A.S. and I.N.A.H. is given for three or four weeks before operation is performed. Sterilization by this means, allows most essential surgery to be attempted in due course.

SUMMARY

It is important where advanced pulmonary or cardio-vascular disease is present, that sufficient time should be allowed for pre-operative treatment. If the operation goes without technical difficulties and complications, it is reasonable to expect a patient with serious heart or lung disease to make a good recovery. Adequate pre-operative assessment, with laboratory, radiological and electrocardiographic examinations by an experienced physician, is always advisable before major surgery is performed.

THE QUESTIONNAIRE

By J. Spivey

THIS ARTICLE ON the social and economic aspects of student life at Bart's is based on the answers received to the Questionnaire from 343 students, 57 of whom are of the fairer sex.

All live in Great Britain and a preponderance have spent most of their lives in the South of England (177). Thirty four come

from the Midlands, 32 from East Anglia, 31 from the North, 28 from Wales, 20 from the West country and a small minority (1) from Scotland.

Schooling

Twice as many people entering Barts went to Public Schools (206) as went to grammar

schools (103). Five went to schools abroad and a further seven went to other schools.

The Public School intake appears to hold General Practice in high favour as a career of choice and some 35 per cent. intend to become general practitioners as compared with the grammar schools 22 per cent. Specialisation in Medicine is the most common ambition of the grammar school intake, but apart from this disparity, the two groups seem to have similar ambitions.

	General	Branch	G.P.	Med.	Surg.	Mid.	Others
<i>of Medicine</i>							
Grammar	22	38	23	11			9
Public	71	56	44	16			19
Abroad	0	0	4	0			1
Other	2	4	1	0			0

Of note also, though perhaps not indicative of a general trend, are the four students from abroad who, of a total entry of five, all wish to become surgeons.

Choice of Medicine as a Profession

The majority seem to have decided to take up medicine between the age of 14 and of leaving school. A small proportion (less than 10 per cent.) made the decision after leaving, and a further 20 per cent decided before the age of 14.

	U-14	14-16	16-leave school	After school
Decided on Medicine as a career	69	103	123	34

Of the factors influencing this decision, the most common ones in the 0-14 group were

- (i) Upbringing in a Medical Household (24.6 per cent).
- (ii) Humanitarian reasons (nearly 19 per cent).

In the 14-16 age group

- (i) Humanitarian Reasons (18.5 per cent).
- (ii) Good financial prospects (16.6 per cent).

but many were drawn by the prospect of meeting people from all walks of life, and others were influenced by their upbringing in a medical household.

16-leaving school:

Good financial prospects seem to have attracted the hard headed A level examinees (17.1 per cent), but humanitarian reasons and interest in science and national history each accounted for another 13.8 per cent. After leaving school:

Eight of the late deciders did so for humanitarian reasons and seven for the promised good financial prospects. At the other end of the scale, only one was swayed by his upbringing in a medical household and one decided for religious reasons.

In general, then, humanitarian reasons are the most popular cause of this decision, though mention must be made of the individual who, seeing no suitable reason provided inserted 'power' in the blank space provided.

Choice of a Hospital

Having decided to take up medicine, a hospital had to be chosen.

The largest group (85) chose Barts for family reasons. Next came the 53 who were first accepted here and 52 who were most influenced by the professional reputation of the Hospital.

One person chose Barts as a result of his or her experiences as a patient here; one because he had strings to pull and one because it was the only hospital he knew of.

Had they not got into Barts, the majority would have gone to St. Thomas's (101) or Guy's (95). Of the newer hospitals, the Middlesex proves the most popular as a second choice (37) and Kings (4) and the Royal Free (three, including one man) are least popular of all.

Eighty eight had parents or close relatives at Barts as a doctor, and 27 as nurses; also the women students have a higher proportion of family association with the Hospital than the men.

A more detailed study of the family connections of the students with medicine in general, reveals that just under 50 per cent of the students' fathers are qualified practitioners and of these, a further 63 per cent have a parent or close relative who is, or at one time was on the staff of this Hospital either as a doctor or as a nurse.

The proportion of mothers qualified in medicine or nursing is rather lower (18.5 per cent), but in these families, there is still a high proportion (45 per cent) with a parent or close relative who is or was on the staff.

These figures do suggest that doctors are not discouraging their children from taking up medicine and certainly the incidence of family linkage with the Hospital is more than can be accounted for by mere coincidence.

Marriage

Marriage has always been a controversial issue amongst students and the indications for and against have long been argued round the coffee table. It is no surprise, therefore, to find that only 3.5 per cent (11) were able to say yes when asked "Are you married?" Of these, two students had families also. The number of engaged was 10.6 per cent (34) and the remainder were single for a variety of reasons.

Of the single group, 57 per cent (167) offered no excuse for not being married; but this group apart, no less than 20 per cent (59) were postponing marriage for reasons of financial strain. A further 13.3 per cent offered 'other' reasons and 8.5 per cent were dissuaded because marriage might interfere with their professional ambition. This left a final group of 1.2 per cent who represented the hardened batchelors and misogynists amongst us.

Accommodation

370 students answered the question: "Where do you live?"

	Single	Engaged	Married	Married with Children
Live with parents	103	6	1	—
College Hall	72	7	—	—
Alone	30	6	3	1
With others	109	19	10	3

Of the engaged students, 85 per cent live away from home, as compared with 67.5 per cent of the single students. Set against this, however, is the fact that the engaged students are probably more advanced in career and years, and although no figures are available, it is not inconceivable that a higher proportion of pre-clinical students live at home. However, despite this suggestion, those figures do pose the question "Are students living away from home more susceptible to predatory ladies than their fellows who live under parental influence and care?"

Perhaps of some surprise also is the number of married students who live with friends and parents and of a total of 18, only four appear to live with their wives alone.

Politics

The political views of those who answered the Questionnaire are tabled below correlated against their educational backgrounds.

	Cons	Lab	Lib	Other	None
Total	204	32	41	11	51
Grammar	51	17	17	3	22
Public	149	12	24	7	27
Abroad	—	—	—	1	22
Other	—	3	—	1	1

One can only speculate, of course, about the odd man out whose education and politics were both 'other', but there is a considerable preponderance of conservative students with the liberals slightly outnumbering the socialists.

As might be expected, the public school entry is considerably more solid conservative than that from Grammar Schools, in fact 53 per cent of the Labour supporters are from the latter schools.

A correlation of the political views of students with their pre-clinical background also gives us some revealing information.

	Cons	Lab	Lib	Other	None
U.L.	149	29	34	8	38
Oxford	15	1	—	1	3
Cambridge	41	2	5	3	10
Other	—	—	1	—	—

We see here that there is a larger proportion of labour supporters amongst those who did their pre-clinical training at Charterhouse, than amongst those from Oxford and Cambridge. There is also more support for the Liberal party amongst those from grammar schools and London University.

Income

Correlating age against annual income, it is found that the Barts Student tends to increase his annual income as he gets older.

In the 18 year age group, some 55 per cent of the students have an annual income of less than £300 p.a. In fact, of these, 80 per cent live on less than £250 p.a., but most of this low income group appear to live at home. (Table I).

There are two, however who live in College Hall and receive less than £250 p.a. It is indeed a long stretch of the imagination to see how this can be done. The annual rent at College Hall is £233 10s. which would leave £16 10s. out of £250 for such luxuries as lunch and drinks. Indeed unless these two are living on charity, one finds it difficult to believe that they can exist at all.

Marriage also seems to bear some relationships to income and the married students

have a considerably higher annual income than the single. (Table II).

Grants appear to be awarded in a rather haphazard manner and sometimes bear no

Table I

	Under £250	£250-300	£300-400	£400-500	£500-600	Over £600
Parents	62	15	9	6	—	3
College Hall	2	5	31	29	10	3
Alone	—	4	11	6	4	2
With others	11	21	54	27	8	8

relation to the student's actual income. Some with very low incomes have no grant at all and others have a high grant, but a much higher income. Of the 326 answers received, 19 (about 6 per cent) have an annual income of less than £250 p.a. and no grant at all and 24 (7 per cent) have incomes which correspond to their grant. At the other end of the

Table II

	Under £250	£250-300	£300-400	£400-500	£500-600	Over £600
Single	69	400	96	54	15	6
Engaged	5	5	13	9	4	—
Married	—	—	—	—	2	11

scale however, 49 (15 per cent) have an annual income £250-450 above their grants whilst the remainder do receive considerable subsidy from persons other than the Minister of Education.

Summary

Apart from one or two extreme examples, it does appear that the Barts student leads a pretty normal life, and indeed, on looking

around one must look far before seeing a companion in dire financial or other difficulties. To most, money is a worry, but no problem; politics stay well below the surface, marriage is considered as seriously as conditions will allow, but few take the plunge.

The revelations in this article may not be sensational, but they do serve to give an objective view of Barts students as they live and put them into perspective with their surroundings.

LETTERS TO THE EDITOR

DEAR SIR,—It should not have escaped your notice that during the last few years there has, among parties interested, been discussion on the decline of British Medicine in the Overseas Territories; the unwillingness of young British graduates now to consider service overseas as a career, either temporarily or permanently; the reasons for this; and how the situation may be remedied. These matters are dealt with at some length by Sir Douglas Robb and in the leading editorial in the current B.M.J. (February 11th) and in the leading editorial in the current *Lancet* (February 11th).

As some have remarked, among the deterrents is the attitude in the teaching hospitals, to which young graduates are naturally very sensitive. When I qualified at Barts over

36 years ago, there was no doubt about it. To deviate from the accepted grooves to consultant or academic rank on the one hand, or refined general practice on the other, and shoot off to such a service as the West African (as I did), was regarded as not only folly and a confession of failure, but a positive insult to Barts. From recent correspondence with the Dean of the Medical School, it is a fair deduction that it still is.

As one writer put it, since the war, British Medicine has appeared to be satisfied with staying indoors and contemplating its navel. As another, more rudely, that Barts retained its lead in the field of auto-omphaloscopy.

The Board of Governors, I suppose, may not be directly concerned with the Medical School, and may take the view that overseas

problems are no business of theirs'. They cannot, of course, dictate to Staff, what their attitudes should be. I can only suggest to you that, if I am correct, this attitude, in a matter of such major importance, is rather deplorable.

Admittedly my own bias is the other way. My career has been in no way distinguished, and there have been many periods when life and work were trying indeed. But for interest, usefulness, variety and amusement I may, without vanity, award it an alpha plus. I think with pity of poor fellows dragging out their lives among the dreary residents of Brighton and Bournemouth, or (Oh! Horror!) a New Town: and without envy of the professors and consultants. After it all I have slid safely into the sixties in good health and reasonably well off. I can only hope that there will be no more discouragement from within to your young men and women to go and do likewise.

I would also suggest that expressions of points of view concerning the Hospital and Medical School, from however lowly a source, should not be despised.

Yours faithfully,

George L. Alexander, M.B., B.Ch. (Camb.),
D.T. M. & H.

West African Medical Staff 1927-48.
Battalion Medical Officer, Abyssinia, 1940-41.
Surgeon, P. & O. and Union-Castle Lines 1948-56.
Ghana and Malaya 1957-59.
The Chairman of the Board of Governors, St. Bartholomew's Hospital.

DEAR SIR,—The portion of Dr. Bamford's report that you published in the January number has impressed me a great deal, for in addition to its pleasant readability (O.E.D.) it contained some excellent ideas.

Under the near-palindromic (not O.E.D.) title of "P.G. study for G.P.'s" he implies that an intending consultant ought to do some work in general practice during his training. I am sure he is quite right in this, for the benefit to the consultant when fledged at last is prodigious; I speak with personal knowledge on this point, and feel that the degree B.G.P. (Been in General Practice) has merits that the more usual B.T.A. (Been To America) has not. The experience is in fact very easily acquired: the only objection against a Registrar doing regular evening surgeries for a general practitioner, and some

week-ends too, is an administrative one and therefore surmountable. Morally there is no objection. Between registrar appointments he can fill in time, and earn money, by doing locums in practice, and this provides even more valuable experience; he can also do the odd fortnight during his six weeks of annual leave. The experience gained is of obvious value to an intending physician, but is probably really of even greater value to a man going in for surgery or any one of the specialties. By a similar paradox, it would benefit a man going in for whole-time academic medicine more than the future part-time man, who will see at least some aspects of general practice when he establishes a private consulting practice.

Dr. Bamford also suggests that general practitioners should come on ward-rounds and contribute to the student teaching. To arrange this is simplicity itself, provided they would do it free of charge. ("Miracles take a little longer.") A Bart's man becomes a perpetual student on qualification and is welcome to attend any of the normal teaching of the College. With very little notice one could select suitable cases for teaching, and quickly get up a lively discussion along the very lines he suggests. I think it would be great fun, and certainly most informative for all of us.

Dr. Bamford has excellent suggestions about general practitioners looking after geriatric beds. One knows that in some geriatric units consultant cover is quite inadequate, and that a more efficient service, such as his plan would lead to, would speed the patients' recovery and discharge. Presumably a consultant would still have to be administratively in charge, if only in order to exercise some central control over the allocation of such beds, pressure for which is enormous throughout the whole country; but I see no particular difficulty in this.

About Merit Awards I am not so sure. In hospitals it is in any case all too common for stupid and prolonged antagonisms to arise between members of the staff; the merit award system is probably the most potent catalyst of this process yet devised. I myself feel, with Mr. R. S. Murley, that "The true reward for distinction is distinction". (Pardon me, Reggie, if I have misquoted you.)

Yours faithfully,

(Dr.) H. Wykeham Balme

DEAR SIR,—The Rugger Club deservedly had a great deal of support, including that of your correspondent, for their Cup matches at Richmond this season. It is well known, however, that those students who stayed away, perhaps having other sporting interests, came in for some criticism for not supporting their hospital at the acknowledged premier sporting occasions of the season.

Those who were so ready and loud with their criticism missed a far better occasion for admonishing their colleagues by not themselves going to the final of the Ladies Hockey Competition. At this match, only five students and some members of the staff troubled themselves to go and support the Hospital team.

There seemed to be few reasons for staying away, the match was advertised both in College Hall and outside the Abernethian Room, a coach was laid on, it was a fine Wednesday afternoon and no examinations were in progress. Only the Boat Club were engaged in particularly important training.

No doubt our valiant supporters of other more popular, or perhaps more social, occasions had their reasons for staying away. would be most interested to read them in these columns, and so too would the Ladies Hockey Team who were visibly disappointed at the lack of support.

But I almost forgot—the Final of the Hospital Rugger Cup was played on the same afternoon, and some of our enthusiasts went down to Richmond instead to watch the teams of two other hospitals. I hardly need draw the conclusion for your readers that for these steadfast supporters of our own functions, the game is of more importance than the hospital.

Thus we can all understand the point of view of those who criticised their fellows for not going down to Richmond.

Yours faithfully,

William Jory.

DEAR SIR,—By the time this circulates, we will be faced with "un fait accompli". However, I feel it worthwhile in attempting a protest against the further municipalisation of the beautiful precincts of College Hall.

This subject has been well-worn in the past and it is recognised that building will soon cause a more major upheaval. But now, some painters have marked out, with dazzling white paint, car parking lots in almost every conceivable space. It is presumed these are to supplant the well-organised parking arena for the moment in use. I also note a couple of untidy floodlights that surely cannot be permanent. Are these to guide the weary worker around the hazardous bends?

However, the necessity for the lines is obscure; they certainly do not enhance the attractiveness of the Charterhouse, to either local or foreign eyes. I would hope that the privileged few, who contravene the Minister of Transport's plea to commute by train, are of sufficient intelligence to park their vehicles in a reasonable manner. One wonders whether all the constructed spaces will be occupied, or will Parkinson's Law apply here and more cars be admitted to fill the gaps.

With this grabbing of squatters' rights by the Parking Committee, it would be good to know that Residents of College Hall—unlike daily commuters—will be guaranteed their small parking zone until it be built upon: official recognition of this in these pages would be appreciated. I trust their resident status will not therefore be totally ignored when construction overtakes the main area; I forget whether anyone has intimated that parking facilities will be incorporated beneath any of the new buildings, a necessary step.

Would the leaders of the senior commuter-car-parkers show a lead by forgoing the pleasure of that agonising drive to and from work? They could then avail themselves of the excellent facilities and relatively cheap service to Aldersgate, a most convenient station. The need for this correspondence would not then arise.

A final thought—I am hard put to find the connection that The City Pram Co. has with the Medical College—a van seems to occupy a slot each day. Is there a crafty solution? I suppose that Elizabeth does create a certain demand!

I remain, yours faithfully,

Brian J. Stoodley.

BOOK REVIEWS

HALE-WHITE'S MATERIA MEDICA, PHARMACOLOGY AND THERAPEUTICS by A. H. Douthwaite, M.D., F.R.C.P. 31st edition. J. & A. Churchill Ltd. 25s.

A new edition of this deservedly popular book has appeared, on the average, every two years since it first appeared in 1892—a commendable record for any book.

This edition has been brought up to date, but, unfortunately, a number of obsolete drugs remain. Thus, for example, picrotoxin continues to be described as useful in cases of barbiturate and paraldehyde poisoning; numerous substances are still recommended as expectorants, whereas current opinion suggests that true expectorants are unknown; and alum, copper sulphate and zinc sulphate are recommended as "commonly used" emetics. It is a pity that these remain in this otherwise excellent book.

The systematic lay-out deserves special comment, and the judicious use of bold type emphasises the main actions and uses of the various drugs. This arrangement makes for very rapid reading, and while the book pre-supposes some knowledge of the subject if one is to derive full benefit from it, it is a most suitable one for preparation for exams in therapeutics. P.J.W.

THE METABOLIC BASIS OF INHERITED DISEASE edited by J. B. Stanbury, J. B. Wyngaarden, D. S. Frederickson. McGraw-Hill Publishing Co. Ltd., New York, Toronto, London. pp. 1,474. 1st Edition. 132s. 6d.

There have been a number of books on biochemical genetics, two notable ones were that by Shia (Inborn Errors of Metabolism, The Year Book Publishers Inc., Chicago, 1959) and by H. Harris (Human Biochemical Genetics, Cambridge University Press, 1959). These two were about 300 pages each, the first is in the nature of an expanded catalogue of inborn errors in man, the second is a much more integrated account which also deals with fundamental problems such as the Watson-Crick hypothesis of deoxyribonucleic acid (DNA) structure. The present book is about five times as big as the other two and much more comprehensive. Its price alone will make it unlikely that students can buy it, but it does represent the first comprehensive and extensive textbook on the subject. There are a large number of authors, some forty-six in addition to the three editors, and as for each subject a specially interested expert has been chosen the standard is universally high. One would recommend particularly the introduction which deals with inherited variation in metabolic abnormality and is an extremely useful summary of the basic concepts of inborn errors of metabolism. There is also a well written account of the biochemical basis of human heredity. Special sections deal with disorders of carbohydrate, amino acid and fat metabolism, others with disturbances in the metabolism of the steroids, purines and pyrimidines, metals and porphyrins, the diseases affecting the formation of the red cells and clotting factors, and with renal tubular transport. The last chapter deals with disorders involving a deficiency of circulating enzymes or plasma proteins and it is here perhaps that most might be added in a future edition. The book

is lavishly illustrated and each chapter is followed by an extensive list of references, sometimes hundreds of them. There could be no better way for a student to get some idea of the huge amount of important new information, which has come into medicine in the last ten years, based on the classical work done at this hospital at the turn of the century by the then Dr. Archibald Garrod. H.L.

OUTLINE OF ORTHOPAEDICS by John Crawford Adams. 3rd Edition. Published by E. and S. Livingstone, Ltd. 35s.

The fact that before the new regulations were introduced a copy of this work was a distinctly *rara avis* in the Library testifies to the esteem in which it is held by the student population! As a clear and lucid outline of orthopaedics rather than a *textbook* it appeals at once to the student who wishes merely to satisfy his examiners rather than treat the subject as a speciality.

In this new edition the chapter on clinical methods has been expanded and some new illustrations added throughout the text. The material is presented under useful headings which greatly aid revision and the somewhat cumbersome chapter on orthopaedic pathology (100 pp.) is very useful to anyone revising this subject. However, the constant references to this chapter from other parts of the text become irritating to anyone trying to read through the book.

Apart from this, criticisms are few in number and some can be excused in view of the authors declared policy of omitting rarities and operative details. To quote one such example, however, I cannot help feeling that in his treatment of "frozen shoulder" the author should have mentioned that many cardiologists, regarding this as one of the earliest symptoms of myocardial ischaemia in a proportion of cases, now recommend a routine E.C.G.

My attention has been called to the fact that for the sake of completeness, a brief note on the obstetric paralyses might with advantage be included. A.J.B.M.

A LABORATORY HANDBOOK OF BLOOD TRANSFUSION TECHNIQUES by A. Derek Far. pp. 135+xi. Heinemann. 17s. 6d.

This little book is intended to cover the general practice of blood transfusion, with particular reference to the examinations of the Institute of Medical Laboratory Technology. Although much of the subject matter is outside the scope of the medical student, the book should certainly find a place in most Pathology Departments, as it contains abundant material valuable both to technicians and to pathologists.

Information is clearly and concisely given, apart from a few minor grammatical errors. The photographs and diagrams are particularly good.

The preparation of pyrogen and bacterial free intravenous solutions is carefully described, with some useful notes on sterilisation technique.

Although blood grouping and cross-matching methods are necessarily reduced to a minimum in a book of this size, such methods have been carefully selected for reliability and safety.

Frequently one finds information that is never given in other, much larger, textbooks. For example, there are helpful passages dealing with the advantages and disadvantages of various blood products, and a table giving the relative costs and durabilities of the types of tubing used in transfusion.

Throughout the book, one is impressed by the author's insistence upon the avoidance of error, and the reduction of blood transfusion risks to a minimum. As he himself says—"the margin of error permissible in blood transfusion work is not wide—it is nil".

A.J.S.

GOOD ENGLISH FOR MEDICAL WRITERS

by Ffrangcon Roberts, M.A., M.D., F.F.R.
Published by William Heinemann Medical Books,
Ltd. pp. 173 + x. 17s. 6d.

This book has been written with the laudable object of helping the would-be author of a medical paper to avoid the many pitfalls of grammar, style, and usage provided by the English language and thereby to make his article more readable and to enable him to convey his meaning more clearly and accurately to the reader. Unfortunately, Dr. Roberts has performed his task with such thoroughness (although there are one or two surprising omissions) and has peppered his pages with such a superabundance of examples of "bad English" quoted from the recent medical literature that the book itself is not very readable. Those who have the patience and endurance to read every one of its sixteen chapters will be rewarded with a great deal of sound and useful advice, but it is to be feared that many readers will be discouraged by the amount of space sometimes devoted to the labours of relatively small points, while others will be put off by the author's occasional tendency to allow personal preference to outweigh the claims of usage, convenience, and common sense. Moreover, although adequately indexed, the book's style and arrangement do not make for easy and rapid reference.

With some judicious pruning—particularly of the quotations, which in many cases are clearly the results

of simple carelessness rather than genuine examples of faulty grammar or construction—this could be a very useful book. But in its present form it hardly presents a serious challenge to the standard works of Fowler or Partridge as the medical author's guide to good English.

D.I.C.

HEALTH AND HORMONES

by A. Stuart Mason, Published by Pelican, 4s.

This is a competent and entertaining do-it-yourself sex and gland book. Although it can be recommended for the intelligent and educated adult lay-public, no dormitory should be without it. I say chaps, have you counted your chromosomes lately!

A. G. S.

CLINICAL ANATOMY

by Harold Ellis, Published by Blackwell, 37s. 6d.

The student of to-day has a great deal more to learn than ever before: the vast subject of anatomy has to be crammed into a short period of learning, so that it is difficult, if not impossible for the facts which will be all important during the clinical training to be appreciated and grasped. Ellis has produced a book which stresses clinical application in anatomy. This must be of value during the preclinical period as a guide to those points which they must retain. During the clinical years anatomy is too easily forgotten. The large books are too large for quick reference, the smaller books are too topographical with little, if any, clinical application, so that the whole important subject is side-tracked by the student. This book fills a real need in the students' preclinical and particularly clinical years of study: in the post-graduate days it would serve as an easy and practical reference book. Such books are difficult to write for the errors of omission surmount those of commission: it is easy to pick out part or parts which are inadequately covered, but there are few such parts in this book, which is practical, well balanced and, above all, easily read.

J. O. R.

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SPORTS NEWS

Viewpoint

It is a moot point whether we play games purely to win, or purely for pleasure, and the truth lies, as in all things human, somewhere between, wrapped in the mysteries of British compromise. A game is no more than a contest between two teams, or two or more players, to find out the better contestant. Let us not forget this—recently there has been a great deal of controversy over the way Test Matches should be played; England play to win, so do Australia and the West Indies (take note Mr. Worrell)—the difference lies in the way each goes about it, and the teams adapt their play to achieve maximum success with the available players and types of wicket.

Few who play, however, will deny that they do enjoy the game, and the less competitive gathering afterwards; in fact, which of us would prefer to play a dull game and win, rather than to lose in a gallant struggle? The essence of the whole thing is that, in the second instance, we play primarily to win, and the harder we play, the more we enjoy it.

There has been a certain amount of criticism recently that the Hospital is not holding its own, and many, though not blaming the teams themselves, ascribe the trouble to our lack of top class players. This is as may be, but let us not forget successes of the cross country team, the ladies hockey team and the chess team. And really, no one can complain about the rugby club after their showing in the cup match.

The addition of two brilliant players each to the rugby, football, and hockey teams (one in the forwards and one in the backs) would doubtless pull them up, but the Hospital has not got them, for some reason they go elsewhere. There is, however, plenty of talent available for coaching. And if this is correctly used, brilliance being met with ability, and enthusiasm the teams will go further than they already have.

Rugby Club

Hospitals Cup Rugby Match

Draw 5-5

PLAYED ON THE firm Richmond ground, with a very strong wind blowing straight down the pitch, this didn't turn out to be the close-up fighting game so often seen in Cup rugby. It was a most exciting and entertaining game in which Bart's rose well above their

current form and came close to winning.

The first half Bart's played with the wind behind them and made good use of it. The long kicks of R. R. Davies, who early on narrowly missed a drop-goal, repeatedly took the Hospital deep into Guys' half. The pack fought very well against far heavier opponents, holding them in the set scrums and getting a lot of the ball from the line-outs where Orr's jumping was prominent. Thus assured of a reasonable share of the ball the Bart's three-quarter line was the more dangerous and opportunist. They were rewarded when, from a Guys handling mistake in mid-field, Britz got his boot to the loose ball, followed up fast and scored. Stevens converted.

At the start of the second half it looked as though a five-point lead might not be sufficient now Bart's were playing against the wind. On the one occasion on which Jeffreys missed his powerful opposite winger it took three men to stop him. However, Halls effectively prevented the Guy's fly-half from setting his line moving while the latters kicking was poorly judged, either going right over the line or straight to Ross at full back. Guys appeared to be held, but from a fine three-quarter movement they scored a try which was also converted. Thus the game ended as a draw with Bart's perhaps slightly unlucky not to have won after their valiant efforts.

Replay

Lost 0-8

The replay was held on a windless day with the hot sun drying the mud to dust. It was a fast exhausting game. To start with, Guys forward onslaughts were held back by long defensive kicks while Bart's backs again looked the more dangerous in attack and sound defence, as witnessed by several shattering tackles by Britz. Once Niven found himself with a large gap, but unluckily he slipped, and the first half ended with no score.

After half-time, the greatly superior weight of the opposing pack began to tell, while their backs found fresh confidence. Desperate covering by Bart's forwards kept repeated attacks in check but eventually a Guy's three-quarter movement brought a try which was converted. Soon after this, Britz had to leave the field with an injured knee and from then on, in spite of fierce running by Stevens,

Bart's no longer looked like scoring. Still Guys had to fight very hard before they gained a second try close to time. The result was a fair reflection of the play for Guys had improved greatly on their previous performance. It was a pity Bart's had not quite succeeded in taking the chance offered by the first game.

Team. A. J. P. Ross, J. Stevens, M. Britz, P. A. R. Niven, R. V. Jeffreys, R. R. Davies, D. Cherney, A. Knox, B. Curry, J. Hamilton, M. M. Orr, B. Doran, R. P. Davies, M. D. Jennings, G. Halls.

Sat., Jan. 28th

1st XV v. Old Paulines. Lost 3-6.

Old Paulines beat Bart's by a try and a penalty goal to a penalty goal. In the first-half, with the wind and slope to their advantage the Paulines deservedly took the lead when centre Britnor cut through in the home '25' to score. After the oranges, although the Old Boys still retained a clear majority in the lines-out, Bart's pressed continuously but despite dangerous runs by S. G. Harris failed to cross the Paulines' line. Close to no-side Harris for Bart's and Wheeler for the Paulines swapped penalty goals from straight in front—the latter's coming in a rare second-half excursion into the Hospital '25'. A. P. Ross played a sound game at full-back.

Team. Ross, Harris, Stevens, Niven, Jeffreys, Davies, Peek, Hamilton, Gurry, Knox, Orr, Thomas, Moynagh, Jennings, Goodall.

Sat., Feb. 4th

1st XV v. Old Merchant Taylors.

Drawn 8-8.

A draw with the accomplished Taylors' side was a most encouraging performance considering the first Cup match was but five days away. The large O.M.T. pack gave their fast three-quarter line much of the ball but a swirling wind made passing hazardous and the Hospital back-row were quick on the resultant mistakes. Bart's scored first when B. H. Gurry crashed over from a line-out but after the interval O.M.Ts equalised when D. G. S. Baker's perfectly placed punt landed in the left wing's arms. An opportunity try by M. C. Jennings who pounced on a dropped pass followed by a fine conversion by J. E. Stevens regained the lead for Bart's but the Old Boys levelled again with a goal

following a blind side break by their scrum-half.

Team. Ross, Stevens, Britz, Niven, Jeffreys, Davies, Peek, Hamilton, Gurry, Knox, Orr, Thomas, Davies, Jennings, Halls.

Sat., Feb. 11th

1st XV v. Esher. Lost 0-29.

The proximity of the Cup matches and the pulled muscles of Halls and R. R. Davies acquired in the opening minutes, which resulted in the former going off and the latter limping through the game finally as a passenger on the wing, contributed to this, the heaviest defeat of the season. A handful of reserves and rank bad Hospital tackling further contributed, but all credit to Esher who slipped smoothly into top gear from the start and gave the spectators a fine exhibition of close inter-passing between forwards and backs interspersed with French-style back row play. A negligible supply of the ball limited the Bart's attacks and seven times the 1st XV stood behind the posts and watched the Esher goal-kicker attempt to convert. He succeeded on four occasions.

Team. E. D. Dorrell, Harris, Britz, Niven, Jeffreys, Davies, Chesney, Harvey, Gurry, Knox, Doran, Orr, Davies, Jennings, Halls.

Sat., Feb. 18th

1st XV v. Metropolitan Police. Lost 9-16

Bart's took on the successful Metropolitan Police side and lost by two penalty goals and a try to two penalty goals and two goals. It was a scrappy game in which two bad defensive lapses cost ten points and nullified the territorial advantage enjoyed in the second-half. An exchange of penalty goals gave the Police a half-time lead of 6-3 which they consolidated with a try under the posts following an interception. Prolonged Bart's pressure followed, but Harris's second penalty goal was the only score to show for this. Then Edwards, the dangerous Police stand-off engineered a scissors with his right wing who ran through the peacefully grazing Bart's forwards to score by the posts. Finally Smart completed a multiple handling movement.

Team. Ross, Harris, Letchworth, Niven, Jeffreys, Davies, Peek, Jennings, Gurry, Shearer, Doran, Orr, Davies, Smart, Halls.

Barts Cross Country Club

THE SEASON STARTED very successfully with an accident: four members of the club arrived at Hampstead to train and found five teams lined up for the start of a race; they joined in and won.

Barts	31 pts.
London Hospital	32 pts.
University College II	44 pts.
Westminster Hospital	68 pts.
Charing Cross Hospital	74 pts.
College of Estate Management	103 pts.
Individual placings: 1st Littlewood, 2nd Foxton, 9th Pott, 19th Hardy.	

The first match in the University's 2nd Division League was held at Parliament Hill on November 2nd. Some misunderstanding made three members of the team late for the start—they were also late for the finish and Bart's were placed 2nd, 3rd, 62nd, 63rd and 64th. This result left us fifth out of ten teams in the league.

On November 23rd it was Bart's turn to entertain the other colleges at Chislehurst. The course is an old U.H. course with a steep half mile hill on road and three quarters of a mile of deep black sticky mud. The "University road-running enthusiasts" took the lead from the start where the going was easy, but on the hill and in the mud Bart's and Guy's made places by the dozen. Littlewood finished first and a minute later Pott appeared hot on the tail of Quintan from Goldsmiths. Foxton ran in fast in sixth position and Lewis finished 12th after a ding-dong battle with three Guys men. The other members of the team marked the course, but in spite of their efforts and 140 arrows cut by Bart's patients, an economist from L.S.E. went off course in the woods. At 5.30 after the police had been informed and the course searched, he arrived grinning from ear to ear and stated that he had got lost!

Imperial College were the hosts on January 25th at Petersham. After the last match Barts were tying second in the division. Over a fast flat course on Richmond Common, Littlewood, Foxton and Pott stayed with the leading bunch and finished 2nd, 3rd and 4th. Macdonald finished 12th, Lewis 13th, Hardy 44th and Phipps 48th. This result brought us into first position in the league.

Having won the Inter-hospitals Cup, we ran the last match at Mitcham—organised

by Kings—full of confidence. Littlewood, Pott and Foxton led the whole way over a very muddy common and finished first equal. Lewis, injured, came 12th, Hardy on top form 22nd and Phipps, after a very good run, 26th.

This excellent result makes Bart's top of Division II and means we shall run in Division I next year.

Besides running for Bart's, Littlewood, Pott, Foxton and Lewis have represented U.H. in nearly every match this season, the latter three have been awarded their U.H. colours. Hardy, Phipps, Macdonald and Phillips have run in U.H. home matches and shown up well against the other hospitals.

The season has also been a great social success thanks particularly to Lewis, and our rivals at Guys.

HOSPITAL CROSS COUNTRY CUP

(New Holders: Bart's)

THE CROSS COUNTRY CLUB scored a well-earned success by winning the inter-hospitals race, run over five miles at Barnet on Saturday, February 4th. It was an afternoon of cold sunshine with grassland sodden and the paths through the woods a quagmire—inches deep in mud. It was just these conditions which we hoped would dull the speed of the race and show up the Bart's strength on heavy going.

At the start it was St. Thomas's and the London who came to the front, though by the end of the first short lap, Bart's were well placed with Pott and Littlewood five yards ahead of Sperryn (St. Mary's) and Brotherhood (St. Thomas's), with Foxton just behind. Sliding through the mud on the way to the railway bridge, Sperryn overtook Littlewood and soon after Brotherhood and Foxton dropped back. This remained the order to Cockfosters Hill where Sperryn lost contact and a win for Bart's seemed assured.

As the Mary's challenge receded, Pott and Littlewood accelerated down the hill to the watersplash and along the road for home. The gap widened through the gruelling morass on the final hill and they finished together almost half a minute ahead of Sperryn.

Foxton fought off a stitch in the middle of the race to finish a creditable 8th, while good packing lower down by the whole of the team increased the margin of the Bart's victory.

Table Tennis Club

Tues., Nov. 22nd (University League)

v. Q.E.C. I. Away. Won 8-2.

Bart's continued their winning run, easily defeating our opponents. A. Eddehsten and A. Miller played up to their usual high standard.

Team. A. Miller (capt.), A. Eddehsten, M. Sandhu.

Tues., Nov. 29th (University League)

v. Q.E.C. II. Home. Won 6-4.

A somewhat weakened Bart's team played very poorly against the reserve team of Q.E.C. and many points were lost by lack of concentration and carelessness.

Team. R. K. Davies, M. Sandhu, A. Miller (capt.).

Tues., Dec. 13th (University League)

v. Q.M.C. (V). Won 7-3.

We finished the term's fixtures with an easy win against Q.M.C. and maintained our unbeaten record. B. Hore did well in his

first match this season to win all his three games.

Team. R. K. Davies, A. Miller (capt.), B. D. Hore.

Swimming Club

WITH THE CLOSE of the 1960-61 season approaching the club's achievements have been as follows:

Winner of the U.H. Knock-out Water Polo Competition—beat St. Mary's in the final.

Second in the U.H. Swimming Championships.

Third in both divisions U.H. Water Polo League.

Second in London University Swimming Championships—the winners of which were Northampton Engineering College. Results of this competition:

Diving—1st D. Shand.

2nd C. Ruoss.

Medley Relay Team—3rd.

Freestyle Relay Team—1st.

Colours have been awarded to Groves, Ruoss, Sharey and Shand.

THE WRITINGS OF SIR HAROLD DELF GILLIES

Compiled by John L. Thornton

1916-17

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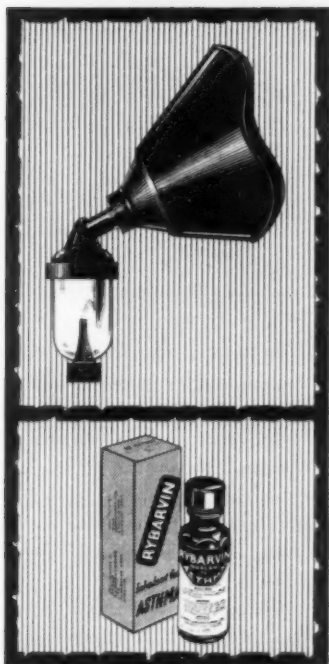


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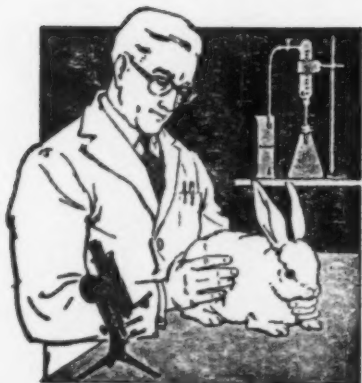
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